TEXAS
Department of
Human Services

COMMISSIONER
James R. Hine

August 28, 2003

To: Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) Providers
Community Care for the Aged & Disabled (CCAD) Residential Care (RC) Providers

Subject: Long Term Care (LTC)
Information Letter No. 03-14
Revisions to Chapter 46, Contracting to Provide Assisted Living and Residential Care Services, **Effective September 1, 2003**

Effective September 1, 2003, the Texas Department of Human Services (DHS) will adopt new rules for the Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) and Community Care for the Aged and Disabled (CCAD) Residential Care (RC) programs. The principle changes of the rules are:

- Re-write existing rules in the plain English style;
- Reorganize the rules to be more user-friendly;
- Incorporate existing policy into rule;
- Provide more complete trust fund instructions and procedures;
- Change CCAD RC policy to require the client to completely pay for room & board services, and to make the payment for these services directly to the facility; and
- Change the bedhold procedures.

Because of the short time frame between this notification and effective dates of these rules, facilities have until October 1, 2003 to comply with these rules, which are different than the existing rules found on Chapter 46.

DHS will revise the CBA Provider Manual and the RC Program Provider Manual in the future. Until the provider manuals are revised, facilities providing CBA AL/RC and CCAD RC services should use the attached Chapter 46 rules in lieu of a provider manual. An electronic version of this letter and the revised Chapter 46 rules can be accessed at: http://www.dhs.state.tx.us/programs/communitycare/index.html.

Please contact your contract manager if you have any questions. Contract managers should contact Sarah Hambrick at (512) 438-2578 for CCAD RC and Rudy Gomez at (512) 438-3740 for CBA AL/RC if they have any questions.

Sincerely,

Signature on file

Becky Beechinor
Assistant Deputy Commissioner
Long Term Care Services

BB:ck

Attachment

August 5, 2003 (3R116)
Title 40, Social Services and Assistance, Part 1, Texas Department of Human Services
Chapter 46, Licensed Personal Care Facilities Contracting with the Texas Department of Human Services to Provide Residential Care Services
Subchapter A, Scope
TAC Section Number(s) §46.1

Final Action
200303650 TRD Docket Number
For Proposed Action

6/27/03 Proposed Action
Publication Date

X Repeal
X Adopted Without Changes

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X 9/1/03

The Texas Department of Human Services (DHS) adopts the repeal of §§46.1, 46.1001, 46.2001, 46.2005, 46.2006, 46.3001, 46.3005, 46.3007, 46.4004-46.4006, 46.5001, 46.7002, 46.8001-46.8003. DHS also adopts new §§46.1, 46.3, 46.11, 46.13, 46.15, 46.17, 46.19, 46.21, 46.23, 46.25, 46.27, 46.31, 46.33, 46.35, 46.37, 46.39, 46.41, 46.43, 46.45, 46.47, 46.49, 46.51, 46.53, 46.61, 46.63, 46.65, 46.67, 46.69, and 46.71, in its Contracting to Provide Assisted Living and Residential Care Services chapter.

New §§46.11, 46.35, 46.37, 46.39, 46.65, 46.67, and 46.69 are adopted with changes to the proposed text published in the June 27, 2003, issue of the Texas Register (28 TexReg 4852). The repeal of §§46.1, 46.1001, 46.2001, 46.2005, 46.2006, 46.3001, 46.3005, 46.3007, 46.4004-46.4006, 46.5001, 46.7002, 46.8001-46.8003; and new §§46.1, 46.3, 46.13, 46.15, 46.17, 46.19, 46.21, 46.23, 46.25, 46.27, 46.31, 46.33, 46.41, 46.43, 46.45, 46.47, 46.49, 46.51, 46.53, 46.61, 46.63, and 46.71 are adopted without changes to the proposed text.

The repeals and new sections were undertaken as part of a DHS project to rewrite agency rules in plain language format to make them easier to use and understand. The new sections also incorporate existing policy into rule language and provide clearer explanations of program policies and definitions in an effort to be as clear and unambiguous as possible. In addition, the proposal incorporates provider requirements for the Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) Program and the Community Care for Aged and Disabled (CCAD) RC Program into the same rule chapter, making them easier for providers and the public to access.

Justification for new §§46.3(18), 46.21(e), 46.27(c)(2)(F)(iv), 46.37, and 46.49(d)(1) is to add a room and board requirement for the CCAD RC Program. In order to meet the funding levels allocated to DHS in the 2004-2005 General Appropriations Act, the proposal requires clients enrolled in the CCAD RC Program to make a room and board payment directly to the facility. Adding this requirement will provide DHS with greater flexibility in funding and administering the CCAD RC Program. This will not increase the total amount of money paid by clients, but will allow this program to continue to serve the needs of enrolled clients within available funding levels.

DHS received written comments from the Texas Assisted Living Association and three individuals and additional oral comments at a public hearing on July 11, 2003. A summary of the

comments and DHS's responses follow.

Comment: Several comments were received expressing concerns about freezing Title XX services. A suggestion was made that each region be allowed to commit the funds that would be needed within that region to fund Residential Care and have the flexibility within that region to shift money between programs and avoid a statewide freeze.

Response: The comment does not directly address a proposed rule so there is no change to a rule. DHS is looking at flexibility in providing Title XX services, which would allow provision of residential care services to people in this environment.

Comment: DHS received a general comment regarding receipts, ledgers, and other bookkeeping documentation. DHS was asked to confirm that facilities may maintain bookkeeping records in a computerized format so long as the records otherwise conform to these regulations.

Response: Sections §46.37(d) and §46.37(e) already use the language “in any format” in reference to documentation requirements. DHS revises §46.67(a)(1) to state that written records may be in any format.

Comment: Concerning §46.11(b)(2), a comment was received stating that current DHS policy allows for multiple facilities to be on the same contract. The commenter appears to be concerned that DHS is changing the contracting practice in this program.

Response: This is not a change in current practice. DHS will continue to use the same contract procedures. DHS adopts the paragraph without change.

Comment: Concerning §46.11(d)(3), a commenter suggested that paragraph (3) may not be necessary because designated rooms are not required by rule.

Response: DHS agrees and deletes this paragraph because the rules no longer require designated rooms.

Comment: In regards to §46.11(d)(4), a concern was expressed that calling an IDT meeting before refusing a referral would bottleneck the system.

Response: The facility contracts to provide services to clients who are the focus of the program. DHS recognizes that a facility may not be able to serve a client. The IDT Meeting is necessary to ensure all options for the client are explored prior to the facility refusing to accept a referral. DHS adopts the paragraph without change.

Comment: Concerning §46.21(h), comments were received expressing concerns that a facility must bill the double occupancy (Residential Care Apartment) rate for clients in the single occupancy (Assisted Living Apartment) setting who request double occupancy. Commenters would also like the clients currently sharing an apartment be “grand fathered” in at the single occupancy rate.

Response: The Health and Human Services Commission (HHSC) rate setting division is responsible for determining the rates for DHS programs. Per HHSC rate setting “The double occupancy rate should be used for all double occupancy situations. The double occupancy rate

charged for the two residents is the intended payment rate for the provider, not the single occupancy rate charged for two residents." HHSC rate setting also states the current clients cannot be "grand fathered" in and must be billed using the proper rate effective September 1, 2003. DHS adopts this section without change.

Comment: In regards to §46.23(2), concerns have been expressed about sanctions based on fiscal monitoring, particularly when the errors are simple mistakes, such as the errors contemplated by subpart (B) and regarding the 12% administrative penalty for simple isolated errors.

Response: The 12% sanction is the administrative portion of the rate. Administrative errors are designed to review service delivery documentation for correct completion of the service delivery records to support billing. The errors listed in §46.23(2)(B)(i)-(xi) are critical to the correct completion of the service delivery documentation. Fiscal monitoring, both administrative and financial errors, is designed to review the documentation that supports service delivery and billing. DHS adopts this subsection without change.

Comment: Concerning §46.35, a commenter expressed concern about the three-day timeframe to convene the Interdisciplinary Team (IDT). One commenter proposed additional language for the rule.

Response: DHS agrees with the comment. DHS accepts the proposed language, with minor stylistic changes, allowing the facility to convene an IDT meeting if all the members are not available to attend the meeting. DHS also adds language that requires the documentation of an IDT meeting without all the IDT members be sent to the Regional Administrator for review. This will ensure the proper DHS staff review the documentation and take the appropriate action.

Comment: In regards to §46.35, a question was asked if sharing health information during an IDT Meeting would be exempt from the consent and authorization requirements of the Health Insurance Portability and Accountability Act (HIPAA).

Response: DHS believes that facilities are able to comply with both the IDT meeting requirements and the HIPAA privacy rules. Because the IDT meets to discuss service delivery issues, DHS believes that an IDT meeting will usually qualify as a "treatment" activity of the facility under the HIPAA privacy rules. If an IDT meeting qualifies as a "treatment" activity of the facility, the HIPAA privacy rules give the facility the option of getting the client's consent to use or disclose protected health information for this activity. Under these circumstances, the facility is not required to get an authorization from the client to use or disclose protected health information. However, DHS cannot conclude that IDT meetings will always qualify as treatment activities of the facilities. Whether they will qualify as treatment activities of the facilities will depend on the precise purpose of the meeting and, perhaps, who attends the meeting. Furthermore, DHS is not responsible for enforcing the HIPAA privacy rules. Facilities should consult with their own privacy officers and lawyers to determine when they should get consents or authorizations to use or disclose protected health information. DHS is not changing this section in response to this comment.

Comment: Concerning §46.37(c)(2) comments were received expressing many concerns about this subsection. The commenters state the rule does not address those instances when a client or client's representative is unable or unwilling to be contacted, and conflicts with monthly billing cycles and statements. Concerns were also expressed about credit balance refunds. One

of the commenters provided some alternative language for §46.37(c)(2).

Response: DHS accepts the proposed language with minor stylistic changes and changes the paragraph. The commenter also suggested five days for the client or the client's representative to respond in §46.37(c)(2)(C). DHS believes this is not enough time, and changes this to 35 days. This allows the client or the representative more time to respond to the notice.

Comment: Concerning §46.37(d)(3), a request was made to not require the payment details on the receipt, if those details are on the copayment and room and board ledger. The commenter requested the facilities be allowed to receipt how much money was paid and then post to the ledger, with the ledger reflecting all charges, credits, and payments per GAAP standards.

Response: DHS agrees, and revises the paragraph to state "Copayment and room and board receipts must contain the following elements if the elements are not contained in the copayment and room and board ledger described in subsection (e) of this section."

Comment: In regards to §46.37(e)(3), a request was made to allow 35 days for ledger entries to be completed.

Response: DHS agrees, and revises §46.37(e)(3) to allow 35 days or by the next billing cycle, whichever is sooner.

Comment: In regard to §46.37(f), several commenters requested deadline be changed to 10 working days. This will give providers a little more time to issue refund checks.

Response: DHS agrees, and changes the deadline to 10 working days.

Comment: In regards to §46.39(d)(3)(B), DHS received several comments stating that assisted living facilities do not have nurses on staff. The commenters would "just like to retain the flexibility that we have under our licensing standards to not have to hire facility nurses to simply do assessments."

Response: DHS does not require the nurse to be a facility employee. DHS revises the rule language in §46.39(d)(3)(B) to clarify that the nurse who completes the medication administration portion of the assessment does not have to be a facility employee.

Comment: In regards to §46.39(d)(3)(B), several comments were received regarding the number of assessments completed for a CBA AL/RC client. The commenters state they feel the three assessments required for CBA AL/RC are duplicative. The commenters would like to "pare it down to where we can limit the redundant assessments."

Response: There are three separate assessments required for a CBA AL/RC client, all serving different purposes and collecting different information. Form 3652 is done as a part of determining client eligibility for the CBA program, and is not a service plan. The HCSS agency completes an assessment that is a service agreement between the HCSS agency and the client, and includes the services the HCSS agrees to provide to the client. The assisted living facility needs to complete an assessment to develop a service agreement between the client and the assisted living facility. This assessment can be used to fulfill the need for an assessment required by licensure. DHS may review consolidation of the assessments in the future. DHS is not changing this subparagraph in response to this comment.

Comment: In regards to §46.39(d)(3)(B), concerns have been expressed regarding the use of a nurse to complete or sign-off on the medication administration portion of the assessment for CBA AL/RC clients. The comments refer to assisted living licensure regulations in 40 TAC §92.41(e). This item does not allow an assisted living facility to "admit or retain … an individual who requires the services of facility employees who are licensed nurses on a daily or regular basis". Another commenter stated that the intent of the "Medications" section "is for facility staff to determine if the resident is able to Self-Administer Medications."

Response: A CBA AL/RC facility is required to provide administration of medications at the level that meets the client's needs as a part of the CBA AL/RC program. The rate for CBA AL/RC includes payment for administration of medication. Administration of medications does not violate §92.41(e). Assisted living facilities are required by statute and rules to provide personal care. The statutory definition of personal care includes the administration of medication. A registered nurse must assess what level of assistance a client needs with medication, and develop a plan of care for medication administration. If the client is unable to self-medicate, the registered nurse must ensure the plan of care for administration of medications is followed. DHS is not changing this subparagraph in response to this comment.

The intent of Section III, Part A, Item 5 of Form 3050 is to determine what level of assistance a client needs with his medications. The CCAD RC Program only allows assistance with self-administered medications. However, the CBA AL/RC Program requires the facility to provide whatever level of medication assistance the client needs, including direct administration of medications. Therefore, for the CBA AL/RC program, the "Medications" section of Form 3050 is to determine how much assistance the client needs with his medications, and a nurse must complete this portion of the assessment.

Comment: In regards to §46.63(d), comments were received requesting a rule change to allow the facility to apply interest earned on a trust fund account to the banking fees on the account. The comments stated that this would be consistent with the Federal SNF guidelines.

Response: Language in this section was patterned after Medicaid Nursing Facility trust fund rules. Banking fees from joint accounts and facility-choice individual accounts are the responsibility of the facility. Banking fees on a client-choice individual account are the responsibility of the client. DHS adopts this section without change.

Comment: Concerning §46.65(d)(7), a request was made to allow petty cash fund reconciliation monthly, as opposed to every 14 days. Comments received state many clients who utilize trust funds pay their bills from their trust fund account, and then get their remaining monthly income as cash from the petty cash fund early in the month. Therefore there is no further activity in the petty cash fund.

Response: DHS agrees, and revises the paragraph.

Comment: In regards to §46.69(b), a request was made to delete the requirement to refund any interest accrued when the trust fund is refunded. Comments received state that the trust fund rules only require the facility to post interest when the bank pays the interest.

Response: DHS agrees, and revises the subsection to state that this refund must include any interest reported as of the date of the request.

The repeal is adopted under the Human Resources Code, Chapters 22 and 32, which authorizes DHS to administer public and medical assistance programs, and under Government Code, §531.021, which provides the Texas Health and Human Services Commission with the authority to administer federal medical assistance funds.

The repeal affects the Human Resources Code, §§22.0001-22.038 and §§32.001-32.053.

§46.1. Scope.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on _____.

Title 40, Social Services and Assistance, Part 1, Texas Department of Human Services
Chapter 46, Licensed Personal Care Facilities Contracting with the Texas Department of Human Services to Provide Residential Care Services
Subchapter B, Definitions
TAC Section Number(s) §46.1001

Final Action
200303651 TRD Docket Number
For Proposed Action

6/27/03 Proposed Action
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X Repeal
X Adopted Without Changes

Effective Date:
X 9/1/03

The repeal is adopted under the Human Resources Code, Chapters 22 and 32, which authorizes DHS to administer public and medical assistance programs, and under Government Code, §531.021, which provides the Texas Health and Human Services Commission with the authority to administer federal medical assistance funds.

The repeal affects the Human Resources Code, §§22.0001-22.038 and §§32.001-32.053.

§46.1001. Definitions of Program Terms.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on _____.

Title 40, Social Services and Assistance, Part 1, Texas Department of Human Services
Chapter 46, Licensed Personal Care Facilities Contracting with the Texas Department of Human

Services to Provide Residential Care Services
Subchapter C, Provider Participation
TAC Section Number(s) §§46.2001, 46.2005, 46.2006

Final Action
200303652 TRD Docket Number
For Proposed Action

6/27/03 Proposed Action
Publication Date

X Repeal
X Adopted Without Changes

Effective Date:
X 9/1/03

The repeals are adopted under the Human Resources Code, Chapters 22 and 32, which authorizes DHS to administer public and medical assistance programs, and under Government Code, §531.021, which provides the Texas Health and Human Services Commission with the authority to administer federal medical assistance funds.

The repeals affect the Human Resources Code, §§22.0001-22.038 and §§32.001-32.053.

§46.2001. Required Services.
§46.2005. Standards for Operation.
§46.2006. Facility Reporting and Notification Requirements.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on _____.

Title 40, Social Services and Assistance, Part 1, Texas Department of Human Services
Chapter 46, Licensed Personal Care Facilities Contracting with the Texas Department of Human Services to Provide Residential Care Services
Subchapter D, Claims Payment
TAC Section Number(s) §§46.3001, 46.3005, 46.3007

Final Action
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For Proposed Action

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X Repeal
X Adopted Without Changes

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X 9/1/03

The repeals are adopted under the Human Resources Code, Chapters 22 and 32, which authorizes DHS to administer public and medical assistance programs, and under Government Code, §531.021, which provides the Texas Health and Human Services Commission with the authority to administer federal medical assistance funds.

The repeals affect the Human Resources Code, §§22.0001-22.038 and §§32.001-32.053.

§46.3001. General Billings/Claims Payment Requirements.
§46.3005. Claims Requirements.
§46.3007. Copayment.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on _____.

Title 40, Social Services and Assistance, Part 1, Texas Department of Human Services
Chapter 46, Licensed Personal Care Facilities Contracting with the Texas Department of Human Services to Provide Residential Care Services
Subchapter E, Provider Contracts
TAC Section Number(s) §§46.4004-46.4006

Final Action
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X Repeal
X Adopted Without Changes

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X 9/1/03

The repeals are adopted under the Human Resources Code, Chapters 22 and 32, which authorizes DHS to administer public and medical assistance programs, and under Government Code, §531.021, which provides the Texas Health and Human Services Commission with the authority to administer federal medical assistance funds.

The repeals affect the Human Resources Code, §§22.0001-22.038 and §§32.001-32.053.

§46.4004. Unit Rate Contracts.
§46.4005. Facility Charges for Hospital/Nursing Facility Stays.
§46.4006. Termination of Contract.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on _____.

Title 40, Social Services and Assistance, Part 1, Texas Department of Human Services
Chapter 46, Licensed Personal Care Facilities Contracting with the Texas Department of Human Services to Provide Residential Care Services
Subchapter F, Records
TAC Section Number(s) §46.5001

Final Action
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For Proposed Action

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Publication Date

X Repeal
X Adopted Without Changes

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X 9/1/03

The repeal is adopted under the Human Resources Code, Chapters 22 and 32, which authorizes DHS to administer public and medical assistance programs, and under Government Code, §531.021, which provides the Texas Health and Human Services Commission with the authority to administer federal medical assistance funds.

The repeal affects the Human Resources Code, §§22.0001-22.038 and §§32.001-32.053.

§46.5001. Record Requirements.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on _____.

Title 40, Social Services and Assistance, Part 1, Texas Department of Human Services
Chapter 46, Licensed Personal Care Facilities Contracting with the Texas Department of Human Services to Provide Residential Care Services
Subchapter G, Support Documents
TAC Section Number(s) §§46.7002

Final Action
200303656 TRD Docket Number
For Proposed Action

6/27/03 Proposed Action
Publication Date

X Repeal

X Adopted Without Changes

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X 9/1/03

The repeal is adopted under the Human Resources Code, Chapters 22 and 32, which authorizes DHS to administer public and medical assistance programs, and under Government Code, §531.021, which provides the Texas Health and Human Services Commission with the authority to administer federal medical assistance funds.

The repeal affects the Human Resources Code, §§22.0001-22.038 and §§32.001-32.053.

§46.7002. Reimbursement Methodology for Residential Care.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on _____.

Title 40, Social Services and Assistance, Part 1, Texas Department of Human Services
Chapter 46, Licensed Personal Care Facilities Contracting with the Texas Department of Human Services to Provide Residential Care Services
Subchapter H, Administrative and Financial Errors
TAC Section Number(s) §§46.8001-46.8003

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X Repeal
X Adopted Without Changes

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The repeals are adopted under the Human Resources Code, Chapters 22 and 32, which authorizes DHS to administer public and medical assistance programs, and under Government Code, §531.021, which provides the Texas Health and Human Services Commission with the authority to administer federal medical assistance funds.

The repeals affect the Human Resources Code, §§22.0001-22.038 and §§32.001-32.053.

§46.8001. Administrative Errors.
§46.8002. List of Administrative Errors.
§46.8003. Financial Errors.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on _____.

Chapter 46, Contracting to Provide Assisted Living and Residential Care Services
Subchapter A, Introduction
TAC Section Number(s) §46.1, §46.3

Final Action
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Publication Date

X New
X Adopted Without Changes

Effective Date:
X 9/1/03

The new sections are adopted under the Human Resources Code, Chapters 22 and 32, which authorizes DHS to administer public and medical assistance programs, and under Government Code, §531.021, which provides the Texas Health and Human Services Commission with the authority to administer federal medical assistance funds.

The new sections affect the Human Resources Code, §§22.0001-22.038 and §§32.001-32.053.

§46.1. Purpose. This chapter establishes the requirements for facilities contracting to provide assisted living and residential care services to eligible clients through the Texas Department of Human Services Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) Program and the Community Care for the Aged and Disabled (CCAD) Residential Care (RC) Program. The requirements described in this chapter apply to both CBA AL/RC and CCAD RC, unless otherwise specified in the text.

§46.3. Definitions. The words and terms used in this chapter have the following meanings, unless the context clearly indicates otherwise.

(1) Assisted living services--Services provided in an assisted living facility to eligible Texas Department of Human Services (DHS) clients under the Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) or the Community Care for Aged and Disabled (CCAD) Residential Care (RC) programs.

(2) Assisted Living/Residential Care (AL/RC) Program--A 24-hour residential care program for CBA clients.

(3) Attendant--A facility employee who provides direct care to clients. An attendant may have other duties in addition to direct client care.

(4) Case manager--A DHS employee who is responsible for case management activities. Activities include eligibility determination, client registration, assessment and reassessment of client need, service plan development, and intercession on the client's behalf.

(5) Client--A CCAD or CBA client, as defined in Chapter 48 of this title (relating to Community Care for Aged and Disabled), who is eligible to receive services under this chapter. (6)

Community Based Alternatives (CBA)--A Medicaid program that provides services to eligible adults who are aged and/or disabled as an alternative to institutional care in a nursing facility. CBA services are provided in accordance with the waiver provisions of §1915(c) of the Social Security Act (42 U.S.C. §1396n(c)).

(7) Community Care for Aged and Disabled (CCAD)--A group of DHS programs that provides a variety of Title XIX and Title XX-funded community-based services.

(8) Contract--The formal, written agreement between DHS and an assisted living facility to provide services to DHS clients eligible under this chapter in exchange for reimbursement.

(9) Contract manager--A DHS employee who is responsible for the overall management of the contract with the assisted living facility.

(10) Contracted assisted living facility--An assisted living facility that contracts with DHS to provide CBA AL/RC services or CCAD RC services or both. Any reference to facility in this chapter means contracted assisted living facility, unless otherwise specified in the text.

(11) Copayment--The amount of personal income a client must pay to the facility toward the cost of care.

(12) Days--Any reference to days means calendar days, unless otherwise specified in the text. Calendar days include weekends and holidays.

(13) Facility manager--The facility employee who is responsible for the day-to-day operation of a facility.

(14) Licensed assisted living facility--A facility licensed by DHS Long Term Care Regulatory under the Health and Safety Code, Chapter 247.

(15) Personal leave day--A continuous 24-hour period, measured from midnight to midnight, when the client is absent from the facility for personal reasons.

(16) Representative--The client's spouse, other responsible party, or legal representative.

(17) Residential Care (RC) Program--An assisted living and emergency care program for CCAD clients.

(18) Room and board--The amount of personal income a client must pay to the facility toward the cost of lodging and food.

(19) Signature--A person's name or a mark representing his/her name on a document to certify it is correct. Initials are not an acceptable substitute for a signature.

(20) Trust fund--The services provided when the facility performs or assists with money management at the written request of the client or the client's representative.

(21) Witness--A person who signs to verify distribution to or from a trust fund. A witness is identified in the client file by name, address, and relationship to the client, the client's representative, or the facility. A witness can be any person except:

(A) the person(s) responsible for accounting for the client's trust fund;

(B) the supervisor of the person(s) responsible for the client's trust fund;

(C) a person supervised by the person(s) responsible for the client's trust fund; or

(D) the person(s) who accepts the withdrawn funds.

(22) Working days--Days DHS is open for business.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on _____.

Chapter 46, Contracting to Provide Assisted Living and Residential Care Services
Subchapter B, Provider Contracts
TAC Section Number(s) §§46.11, 46.13, 46.15, 46.17, 46.19, 46.21, 46.23, 46.25, 46.27

Final Action
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X New
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Effective Date:
X 9/1/03

The new sections are adopted under the Human Resources Code, Chapters 22 and 32, which authorizes DHS to administer public and medical assistance programs, and under Government Code, §531.021, which provides the Texas Health and Human Services Commission with the authority to administer federal medical assistance funds.

The new sections affect the Human Resources Code, §§22.0001-22.038 and §§32.001-32.053.

§46.11. Contracting Requirements.

(a) General contracting requirements. A facility must meet all provisions described in this chapter and Chapter 49 of this title (relating to Contracting for Community Care Services).

(b) Assisted living services contracting requirements. To qualify to provide assisted living services under contract with the Texas Department of Human Services (DHS), a facility must comply with the following requirements:

(1) The facility must be licensed as defined in §92.4 of this title (relating to Types of Assisted Living Facilities). The facility must be allowed under licensure to provide the required services described in §46.41 of this chapter (relating to Required Services). Due to the licensure requirements, Type C and Type E facilities are not able to provide the required services under this chapter.

(2) The facility must have a separate contract for each facility that provides assisted living services.

(3) The facility must specify the number of beds for DHS clients in its contract, as follows:

(A) The facility must ensure that the number of beds contracted are in rooms that meet the requirements in §46.13 of this chapter (relating to Housing Options).

(B) The facility must ensure the number of DHS clients served by the facility does not exceed the number of contracted DHS beds.

(C) The facility may adjust the number of beds for DHS clients by contract amendment.

(4) The facility must comply with all other applicable DHS rules and regulations.

(c) Disclosure statement requirements. The facility must ensure that the Assisted Living Disclosure Statement, as required by Chapter 92 of this title (relating to Licensing Standards for Assisted Living Facilities), does not conflict with the program requirements.

(d) Client referrals. The facility must accept all DHS referrals unless:

(1) the referral would cause the facility to exceed licensed capacity;

(2) the referral would cause the facility to exceed the number of beds for DHS clients that the facility has specified in its contract; or

(3) the facility is unable to meet the client's needs and has followed the procedures described in §46.35 of this chapter (relating to Interdisciplinary Team).

(e) Contract assignment. In addition to the procedures described in §49.5 of this title (relating to Contract Assignment), the facility must follow the procedures described in §46.71 of this chapter (relating to Trust Fund Procedures for Client Discharge) for assignment of the trust fund account and records.

§46.13. Housing Options.

(a) Setting. A facility must specify in the contract the type(s) of setting(s) it uses to provide assisted living services according to the following guidelines:

(1) Assisted living apartment. An assisted living apartment setting is a living unit that is a private space with living and sleeping areas, a kitchen, a bathroom, and adequate storage space. The bedroom must be single occupancy, except when the participant requests double occupancy in writing. The living unit must have private kitchen and bath facilities.

(A) Size. Assisted living apartments must have a minimum of 220 square feet, not including the bathroom. Current contracted assisted living apartments that do not meet the square footage requirement may remain at their current size unless the apartment is remodeled. Remodeling includes:

(i) the construction, removal, or relocation of walls and partitions;

(ii) the construction of foundations, floors, or ceiling-roof assemblies;

(iii) the expansion or alteration of safety systems, including:

(I) sprinkler;

(II) fire alarm; and

(III) emergency systems; or

(iv) the conversion of space in a facility to a different use.

(B) Kitchen. The kitchen is an area equipped with a sink, refrigerator, a cooking appliance, adequate space for food preparation, and storage space for utensils and supplies. The cooking appliance must be a stove, microwave, or built-in surface unit. The cooking appliance must be able to be removed or disconnected.

(C) Bathroom. The bathroom must be a separate room in the individual's living area with a toilet, sink, and an accessible bath.

(2) Residential care apartment. A residential care apartment setting is a living unit that is a private space with connected sleeping, kitchen, and bathroom areas and adequate storage space. The bedroom must be double occupancy. The living unit must have private kitchen and bath facilities.

(A) Size. Residential care apartments must have a minimum of 350 square feet of space per client. Indoor common areas used by Texas Department of Human Services (DHS) clients must be included in computing the minimum square footage. The portion of the common area allocated must not exceed usable square footage divided by the maximum number of individuals who have access to the common areas.

(B) Kitchen. The kitchen is an area equipped with a sink, refrigerator, a cooking appliance, adequate space for food preparation, and storage space for utensils and supplies. The cooking appliance must be a stove, microwave, or built-in surface unit. The cooking appliance must be able to be removed or disconnected.

(C) Bathroom. The bathroom must contain a toilet, sink, and an accessible bath.

(3) Residential care non-apartment. A residential care non-apartment setting is a living unit that does not meet either the definition of an assisted living apartment or a residential care apartment. A residential care non-apartment must be double occupancy.

(A) The facility that specifies the residential care non-apartment setting must be a freestanding building not physically attached to another licensed facility.

(B) The facility must be licensed as an assisted living facility with a capacity of 16 or fewer beds.

(4) Personal Care 3. A Personal Care 3 setting is only available in the Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) Program, and must meet the following qualifications:

(A) The facility must be licensed for four to 16 beds in a residential care non-apartment setting.

(B) The facility must provide 60% or more of its CBA clients with a single occupancy bedroom.

(C) The facility must maintain a minimum staffing ratio of one direct care staff member for every:

(i) four clients, including private pay clients, during the day and evening shifts; and

(ii) eight clients, including private pay clients, during the night shift.

(D) Sixty percent or more of the total clients served each month must require one-to-one staff assistance. One-to-one assistance is determined by a value of three or more on the DHS Client Assessment, Review, and Evaluation form in one or more of the following activities of daily living:

(i) transferring;

(ii) eating; or

(iii) toileting.

(b) Occupancy. The facility must provide each client with a private (singe occupancy) or semi-private (double occupancy) living unit.

§46.15. Additional Services and Fees.

(a) The facility may charge the client or the client's representative for additional items or services that the Texas Department of Human Services (DHS) does not require the facility to provide. The client or the client's representative must request and approve the additional items or services in writing.

(b) The facility must not charge the client or the client's representative for any service provided to the client as required by its contract with DHS.

(c) The facility must inform the client or the client's representative of the additional items or services and the charges for those items or services at the following times:

(1) at admission;

(2) before a change in the additional items, services, or charges; and

(3) when the client requests the additional items or services.

(d) The facility may charge the client or the client's representative for additional items or services, including:

(1) private telephone;

(2) television and/or radio for personal use;

(3) cable television services;

(4) personal comfort items, including smoking materials, notions and novelties, and confections;

(5) cosmetics and grooming items and services in excess of those required;

(6) personal clothing;

(7) personal reading material;

(8) gifts purchased on behalf of a client;

(9) flowers and plants;

(10) social events and entertainment outside the scope of the required activities program;

(11) the cost of being a single occupant in a double occupancy room, except for:

(A) a therapeutically required single occupancy room, such as isolation for infection

control; or

(B) services provided in the assisted living apartment setting, as defined in §46.13(a)(1) of this chapter (relating to Housing Options);

(12) specially prepared or alternative food requested instead of the food generally prepared by the facility;

(13) the actual amount of the fee charged by the bank for checks written by the client or the client's representative that are returned for non-sufficient funds;

(14) charges for damage to the facility beyond expected wear and tear. The facility must not charge a security/damage deposit to DHS clients; and

(15) pet deposit. A pet deposit does not apply to service animals. A service animal is any guide dog, signal dog, or other animal trained to provide assistance to an individual with a disability.

§46.17. Termination of Contract.

(a) General requirements for termination. The Texas Department of Human Services (DHS) will terminate the facility's contract as described in Chapter 49 of this title (relating to Contracting for Community Care Services) or as otherwise described in this chapter or the facility's contract with DHS.

(b) Physical location. DHS will terminate the facility's contract if the facility loses the right to occupy the physical premises identified as the service delivery location. The contract termination is effective on the date the facility loses its right to occupy the physical premises, unless DHS notifies the facility of a later termination date. DHS will not pay for services provided after the termination date.

(c) Payment suspension. DHS may suspend the facility's payments if the contract is terminated for any reason at any time other than the last day of a month. Payments will remain suspended until the facility has refunded all unearned copayment and room and board payments and all trust fund balances to all clients served.

§46.19. Recordkeeping.

(a) General documentation requirements. The facility must maintain the documentation described in Chapter 49 of this title (relating to Contracting for Community Care Services).

(b) Record retention requirements. The facility must retain records for the time periods described in §69.205 of this title (relating to Contractor's Records).

(c) Daily service delivery documentation. The facility must document the client's daily service delivery.

(1) The daily service delivery documentation must contain the:

(A) client name;

(B) facility vendor number issued by Texas Department of Human Services (DHS);

(C) coverage period of the daily service delivery documentation;

(D) tasks assigned;

(E) tasks performed during the coverage period;

(F) signature of the facility manager or supervisor; and

(G) date of signature of the facility manager or supervisor.

(2) The daily service delivery documentation must be on a single document. If services delivered during the coverage period exceed the space on the single document, the facility may use multiple pages. The daily service delivery document must clearly indicate the number of pages used for the coverage period.

(d) Daily census documentation. The facility must document the daily census of clients.

(1) The daily census documentation must contain the:

(A) name of the facility;

(B) facility vendor number issued by DHS;
(C) coverage period of the daily census documentation;
(D) name of each client served during the coverage period;
(E) daily status of each client for each day during the coverage period. Types of daily status are:
(i) admission;
(ii) discharge;
(iii) present;
(iv) personal leave;
(v) institutional leave;
(vi) emergency care (emergency care applies only to the Community Care for Aged and Disabled (CCAD) Residential Care (RC) program); and
(vii) ineligible emergency care (ineligible emergency care applies only to the CCAD RC program);
(F) total of each type of daily status during the coverage period;
(G) signature of the authorized timekeeper; and
(H) date of the authorized timekeeper's signature.

(2) The daily census documentation must be on a single document. If the number of clients served during the coverage period exceeds the space on the single document, the facility may use multiple pages. The daily census document must clearly indicate the number of pages used for the coverage period.

(e) Financial records. The facility must maintain financial records:

(1) to support its billings to DHS for payment under §46.21 of this chapter (relating to Reimbursement);

(2) to document reimbursements made by DHS. The documentation must include:
(A) amount of reimbursement;
(B) voucher number;
(C) warrant number;
(D) date of receipt; and
(E) any other information necessary to trace deposits of reimbursements and payments made from the reimbursements in the facility's accounting system.

(3) in accordance with generally accepted accounting principles (GAAP) and DHS procedures. A facility's financial records must include but are not limited to the following:
(A) deposit slips, bank statements, cancelled checks, and receipts;
(B) purchase orders;
(C) invoices;
(D) journals and ledgers;
(E) timesheets and payroll and tax records;
(F) inventory records for food and other supplies;
(G) Internal Revenue Service, Department of Labor, and other government records and forms;
(H) records of insurance coverage, claims, and payments (for example, medical, liability, fire and casualty, and worker's compensation);
(I) equipment inventory records;
(J) records of the facility's internal accounting procedures;
(K) chart of accounts, as defined by GAAP; and
(L) records of the facility's company policies.

(f) Subcontractor records. If a provider agency utilizes a subcontractor, the provider agency must maintain records of the subcontractor's activities. Maintenance of all records to support subcontractor claims is the responsibility of the provider agency.

(g) Registered nurse access. The facility must allow the home and community support services agency's registered nurse access to the client's medical and service plan records for use in the assessment.

§46.21. Reimbursement.

(a) The facility must bill for services provided as described in Chapter 49 of this title (relating to Contracting for Community Care Services).

(b) The Texas Department of Human Services (DHS) will pay for eligible services provided and billed in compliance with this chapter.

(c) A unit of service is one billable day of authorized service delivered to a client.

(d) The facility must agree to accept the unit rate authorized by DHS, plus any applicable room and board payments, as payment in full for services required by DHS.

(e) The unit rate reimbursed by DHS includes any copayment. The combined reimbursement from DHS and the client or the client's representative for the required services described in §46.41 of this chapter (relating to Required Services) must not exceed the unit rate plus room and board specified for each type of setting. The unit rate does not include charges for services described in §46.15 of this chapter (relating to Additional Services and Fees).

(f) The facility must deduct the copayment amount from reimbursement claims submitted to DHS.

(g) The facility must not bill DHS for the day of discharge, unless the discharge is due to the death of the client.

(h) The facility must bill the double occupancy (Residential Care Apartment) rate for clients in the single occupancy (Assisted Living Apartment) setting who request double occupancy.

(i) The facility must bill DHS for the balance of the bedhold charge for any clients whose daily copayment is less than the maximum bedhold charge allowed by DHS.

(1) The facility must determine the client's daily copayment amount by dividing the client's monthly copayment charge by the number of days in the month.

(2) The facility must deduct the client's daily copayment amount from the bedhold rate and submit the claim to DHS.

(3) This subsection does not apply to the Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) Program.

(j) The facility may bill DHS for emergency care provided to clients for:

(1) up 60 days per authorization for eligible clients; or

(2) five days for a client ineligible for emergency care.

(k) The facility must not bill for services provided before or after the authorized effective dates for CBA AL/RC or Community Care for Aged and Disabled (CCAD) Residential Care (RC) services, as those dates are determined by DHS.

(l) When the facility requests a Texas Index of Level of Effort (TILE) reset, the facility may bill DHS at the new TILE level effective the date of the TILE assessment. The facility may request only two TILE resets during each calendar year for each CBA client for the following time periods:

(1) January through June; and

(2) July through December.

(m) CCAD RC services will be reimbursed at the double occupancy rate, regardless of the actual occupancy.

§46.23. Monitoring Reviews. Monitoring reviews are conducted through an on-site review and in accordance with Chapter 49 of this title (relating to Contracting for Community Care Services). The Texas Department of Human Services (DHS) reviews records on a regular and systematic basis, and as often as DHS deems necessary. DHS conducts the following types of monitoring:

(1) Compliance monitoring. Compliance monitoring is a review to determine if the facility is delivering services according to the rules in this chapter. Compliance monitoring includes:

(A) review of consumer satisfaction surveys conducted;

(B) review of client records;

(C) interviews with clients and staff;

(D) observation of clients and staff; and

(E) consultations with others as appropriate.

(2) Fiscal monitoring. Fiscal monitoring is a review of documentation that supports the facility's billing. The facility is liable for recoupment of payment if monitoring errors indicate the monthly claims do not correspond with the daily census documentation and daily service delivery documentation. Fiscal monitoring includes:

(A) Financial errors. DHS applies the error to the entire unit of service. Financial errors include:

(i) The facility is reimbursed for services, but the daily census documentation and the daily service delivery documentation are missing for the period for which services are reimbursed. DHS applies the error to the total number of units reimbursed for the billing period for which forms are missing.

(ii) The facility is reimbursed for units that exceed the units recorded on daily census documentation and daily service delivery documentation. DHS applies the error to the total number of units reimbursed in excess of units recorded.

(iii) The facility is reimbursed for units of service and the client did not receive services. DHS applies the error to the total number of units reimbursed for the days the client did not receive services.

(iv) The facility is reimbursed for units of service and the client was Medicaid ineligible. DHS applies the error to the total number of units reimbursed for the days the client was Medicaid ineligible. This does not apply to the Community Care for Aged and Disabled (CCAD) Residential Care (RC) program.

(B) Administrative errors. Documentation is reviewed for administrative errors as they exist at the time DHS staff arrive to conduct the monitoring review. DHS applies the error to the administrative portion of the unit of service. The administrative portion is 12% of the paid unit rate. Administrative errors include:

(i) The facility enters a date of signature on the daily census documentation that is before the date the last day services are provided. DHS applies the error to the total number of units reimbursed after the signature date.

(ii) The facility fails to sign the daily census documentation. DHS applies the error to the total number of units reimbursed on the unsigned form.

(iii) The facility fails to enter a date of signature on the daily census documentation to certify total number of units provided to the client. DHS applies the error to the number of units reimbursed on the undated form.

(iv) The facility corrects the date of signature on the daily census documentation, but fails to initial the correction. DHS applies the error to the total number of units reimbursed after the earliest signature date.

(v) The facility uses a signature stamp on the daily census documentation, but fails to initial the stamped signature. DHS applies the error to the total number of units reimbursed on the signature stamped form.

(vi) The facility makes an illegible entry or illegible correction to any portion of the record of time on the daily census documentation. DHS applies the error to the total number of units reimbursed for the days in which entries are illegible.

(vii) The facility enters an illegible date of signature or makes an illegible correction to the date of signature on the daily census documentation. DHS applies the error to the total number of units on the form.

(viii) The facility fails to complete the entire daily census documentation in ink, as described in §49.11(d) of this title (relating to Record Documentation Requirements). DHS applies the error to the total number of units reimbursed that were not completed in ink.

(ix) The facility uses a method other than crossing out and initialing to change an entry on the daily census documentation. DHS applies the error to the total number of units reimbursed that were corrected in a manner other than crossing out and initialing.

(x) The facility fails to list the client on the daily census documentation, but the client was listed on the daily service delivery documentation. DHS applies the error to the total number of units reimbursed for the period the client was left off the daily census documentation.

(xi) The facility leaves the daily status blank on the daily census documentation, but daily activity can be verified on the daily service delivery documentation. DHS applies the error to the total number of units reimbursed for which the daily status is left blank on the daily census documentation.

§46.25. Complaints. A facility must comply with the complaint procedures described in §49.13 of this title (relating to Client Rights and Responsibilities) and §49.14 of this title (relating to Complaint Procedures).

§46.27. Reimbursement Methodology for Residential Care.

(a) General requirements. The Texas Department of Human Services (DHS), or its designee, applies the general principles of cost determination as specified in §20.101 of this title (relating to Introduction).

(b) Cost reporting.

(1) Providers must follow the cost-reporting guidelines as specified in §20.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(2) All contracted providers must submit a cost report unless the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer.

(3) The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any regulatory agency. Requests to be excused from submitting a cost report must be received by the Texas Health and Human Services Commission’s (HHSC) Rate Analysis department before the due date of the cost report.

(c) Reimbursement determination.

(1) Reporting and verification of allowable costs.

(A) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursements. DHS or its designee excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information that are necessary for the provision of services and that are consistent with federal and state regulations.

(B) Individual cost reports may not be included in the database used for reimbursement determination if:

(i) there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported; or

(ii) an auditor determines that reported costs are not verifiable.

(C) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for the reason stated in subparagraph (B)(i) of this paragraph.

(2) Residential care reimbursement. Recommended per diem reimbursement for residential care is determined as follows.

(A) Reported allowable expenses are combined into four cost areas:

(i) attendant;

(ii) other direct care;

(iii) facility; and

(iv) administration and transportation.

(B) Facility, transportation (vehicle), and administration expenses are lowered to reflect expenses for a provider at the lower of:

(i) 85% occupancy rate; or

(ii) the overall average occupancy rate for licensed beds in facilities included in the database during the cost-reporting periods included in the base. The occupancy adjustment is applied if the provider's occupancy rate is below 85% or the overall average, whichever is lower. The occupancy adjustment is determined by the individual provider occupancy rate being divided by .85 or the average occupancy rate of all providers in the database.

(C) Payroll taxes and employee benefits are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense for the appropriate group of staff. Employee benefits will be charged to a specific salary line item if the benefits are reported separately. The allocated payroll taxes and employee benefits are Federal Insurance Contributions Act or Social Security, Medicare contributions, Workers' Compensation Insurance, the Federal Unemployment Tax Act, and the Texas Unemployment Compensation Act.

(D) Allowable salaries paid to the director, administrator, assistant administrator, owner, or partner who works for the Residential Care contracted provider may be limited to the 90th percentile of an array of salary costs for the director, administrator, assistant administrator, owner, or partner.

(E) The attendant cost area from subparagraph (A)(i) of this paragraph will be calculated as specified in §20.112 of this title (relating to Attendant Compensation Rate Enhancement).

(F) The following applies to the cost areas from subparagraph (A)(ii)-(iv) of this paragraph:

(i) Each provider's total reported allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost-reporting period to the prospective reimbursement period as described in §20.108 of this title (relating to Determination of Inflation Indices). The prospective reimbursement period is the period of time that the reimbursement is expected to be in effect.

(ii) Cost area per diem expenses are calculated by dividing total reported allowable costs for each cost area by the total days of service. Cost area per diem expenses are rank ordered from low to high to produce projected per diem expense arrays.

(iii) Reimbursement is determined by selecting from each cost area the median day of service and the corresponding per diem expense times 1.07. The resulting cost area amounts are totaled to determine the per diem reimbursement.

(iv) The client is required to pay the room and board portion of the per diem reimbursement. DHS will pay the services portion of the per diem reimbursement.

(3) Exceptions to the reimbursement determination methodology. Reimbursement may be adjusted in accordance with §20.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs) when new legislation, regulations, or economic factors affect costs.

(d) Authority to determine reimbursement. The authority to determine reimbursement is specified in §20.101 of this title.

(e) Allowable and unallowable costs. In determining whether a cost is allowable or unallowable, providers must follow the guidelines as specified in §20.102 of this title (relating to General Principles of Allowable and Unallowable Costs) and §20.103 of this title (relating to Specifications for Allowable and Unallowable Costs). In addition to these sections, the following allowable and unallowable costs are applicable in the Community Care for Aged and Disabled Residential Care program.

(1) Allowable costs. Medical supplies required to provide residential care services are allowable. Allowable medical costs include supply costs associated with the administration of medications, such as medication cups, syringes for insulin injections, stethoscopes, blood pressure cuffs, and thermometers.

(2) Unallowable costs. Unallowable costs include prescription drugs; non-legend drugs; medical records costs; and compensation for physicians, pharmacists, and medical directors.

(f) Reporting revenue. Revenues must be reported on the cost report in accordance with §20.104 of this title (relating to Revenues).

(g) Reviews and field audits of cost reports. Desk reviews or field audits are performed on cost reports of all contracted providers. The frequency and nature of the field audit are determined by DHS or its designee to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §20.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and providers will be notified of the results of a desk review or a field audit in accordance with §20.107 of this title (relating to Notification of Exclusions and Adjustments). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken under §20.110 of this title (relating to Informal Reviews and Formal Appeals).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on _____.

Chapter 46, Contracting to Provide Assisted Living and Residential Care Services
Subchapter C, Provider Requirements
TAC Section Number(s) §§46.31, 46.33, 46.35, 46.37, 46.39, 46.41, 46.43, 46.45, 46.47, 46.49, 46.51, 46.53

Final Action	
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X 9/1/03

The new sections are adopted under the Human Resources Code, Chapters 22 and 32, which authorizes DHS to administer public and medical assistance programs, and under Government Code, §531.021, which provides the Texas Health and Human Services Commission with the authority to administer federal medical assistance funds.

The new sections affect the Human Resources Code, §§22.0001-22.038 and §§32.001-32.053.

§46.31. Staff Requirements. The facility must have staff as described in §92.41 of this title (relating to Standards for Type A, Type B, and Type E Assisted Living Facilities).

§46.33. Staff Training.

(a) General training requirements. The facility must provide all staff with training as described in §92.41 of this title (relating to Standards for Type A, Type B, and Type E Assisted Living Facilities).

(b) Facility manager. In addition to the requirements described in subsection (a) of this section, the facility must train the facility manager on the following topics:

(1) facility requirements for the Community Care for Aged and Disabled (CCAD) Residential Care (RC) or Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) programs or both, as applicable; and

(2) client characteristics and needs.

(c) Attendants. In addition to the requirements described in subsection (a) of this section, the facility must train the attendant in performing the tasks identified on the service plan described in §46.39(d) of this chapter (relating to Service Initiation).

(d) Training of new staff. The facility must provide training to new staff hired after the initial orientation described in §49.3(b) of this title (relating to General Contractual Requirements).

§46.35. Interdisciplinary Team.

(a) Interdisciplinary Team (IDT). The IDT is a designated group that includes the following individuals who meet when the need arises to discuss service delivery issues:

(1) the client or the client's representative, or both;

(2) a facility representative; and

(3) a Texas Department of Human Services (DHS) representative. A DHS representative may be:

(A) the case manager (or designee);

(B) the contract manager (or designee); or

(C) the regional nurse (or designee).

(b) Convening an IDT meeting.

(1) The facility must convene an IDT meeting within three working days of the date the facility identifies a service delivery issue.

(2) If the facility is unable to convene an IDT meeting with all the members described in subsection (a) of this section, the facility must send the documentation of the IDT meeting described in subsection (e) of this section to the Regional Administrator for the DHS region in which the client resides.

(A) The documentation must be sent within five working days of the date of the IDT meeting.

(B) Further action may be required by the facility, based on a review of the IDT

meeting documentation.

(c) IDT meeting.

(1) The IDT meeting may be conducted by telephone conference call or in person.

(2) The IDT must:

(A) evaluate the issue;

(B) identify any solutions to resolve the issue; and

(C) make recommendations to the facility.

(d) IDT meeting outcome. The facility must do one of the following within two working days after the IDT meeting:

(1) implement the recommendations of the IDT; or

(2) discharge the client from the facility and refer the case back to the case manager for referral to another facility.

(e) Documentation of the IDT meeting. The facility must document the IDT meeting in the client file, including the:

(1) specific reasons for calling the IDT meeting;

(2) participants of the IDT meeting. If all members described in subsection (a) of this section are unable to participate, the facility must document all efforts made to convene an IDT meeting with all the members.

(3) recommendations of the IDT;

(4) efforts made to resolve the issue;

(5) facility's action as a result of the IDT recommendations; and

(6) reasons for the facility's actions.

§46.37. Copayment and Room and Board.

(a) Amount. The facility must collect the copayment and room and board amounts indicated on the Texas Department of Human Services' (DHS's) Notification of Community Care Services form or DHS's Notification of Community Based Alternatives (CBA) Services form. This subsection does not apply to clients who receive Community Care for Aged and Disabled emergency care service.

(b) Due date.

(1) The facility must designate a due date for copayment and room and board in writing. The due date must be during the same month the copayment and room and board is applied.

(2) The facility must collect the entire copayment and room and board on or before the due date. If the due date falls on a weekend or a holiday, the facility must collect the entire copayment and room and board on or before the first working day thereafter.

(3) If the client or the client's representative fails to pay the entire copayment and room and board by the due date, the facility must notify the client or the client's representative and the case manager in writing no later than the first working day after the due date.

(c) Credit balances.

(1) A credit balance is an amount due to the client or the client's representative when there is an overpayment by the client or the client's representative.

(2) The facility must handle credit balances as follows:

(A) The facility must provide written notice of a credit balance (client notice) to the client or the client's representative within 35 days of receipt of the payment resulting in a credit balance. The client notice may be the first monthly statement following the receipt of the payment resulting in a credit balance, if the monthly statement specifies the credit balance.

(B) The facility must offer the client or the client's representative the following options in the client notice:

(i) the client or the client's representative may choose to provide the corrected payment, and the facility will return the original amount paid;

(ii) the facility will provide the client or the client's representative with a refund of the credit balance; or

(iii) the client or the client's representative may choose to have the credit balance applied to the following month's payment. The client may choose to spread the credit balance over several months.

(C) If the client or the client's representative fails to contact the facility within 35 days of the date of the client notice, the facility must, on the 35th day:

(i) provide the client or the client's representative with a refund of the credit balance or apply the credit balance to the following month's payment; and

(ii) provide written notice of the facility's choice of action to the client or the client's representative. The written notice of the facility's choice of action may be a monthly statement if the monthly statement specifies the facility's choice of action.

(d) Copayment and room and board receipts.

(1) The facility must provide receipts for all copayment and room and board payments received from or on behalf of clients at the time the payment is received.

(2) The facility must keep a copy of all copayment and room and board receipts.

(3) Copayment and room and board receipts must contain the following elements if the elements are not contained in the copayment and room and board ledger described in subsection (e) of this section:

(A) the name of the client;

(B) the month, day, and year the payment was received;

(C) the total amount collected;

(D) the specific amounts of copayment and room and board collected; and

(E) the month and year of the coverage period for the payment received.

(4) Copayment receipts may be in any format.

(e) Copayment and room and board ledger. The facility must maintain a copayment and room and board ledger system in any format for each client.

(1) The facility may keep the copayment and room and board ledger systems as separate ledgers, or the facility may combine both ledgers into a single ledger system. If the facility chooses to keep a single ledger system, a separate entry must be made for each copayment and room and board entry.

(2) The copayment and room and board ledger system must reflect the following:

(A) all charges for copayment and room and board by client;

(B) all payments for copayment and room and board made by or on behalf of a client;

(C) all credits for copayment and room and board by client, including the:

(i) specific amount credited;

(ii) month and year of the coverage period of the credit;

(iii) type of payment credited; and

(iv) reason for the credit; and

(D) a running balance by client.

(3) The facility must record all activities on the copayment and room and board ledger system within 35 days or by the next billing cycle, whichever is sooner.

(4) The copayment and room and board ledger must be maintained in accordance with generally accepted accounting principles (GAAP).

(f) Refunds upon discharge. The facility must refund the client's copayment and room and board for the remaining days of the month following the date of discharge or death. The refund must be made within ten working days of awareness that the client will be discharged or is deceased. The facility must document the date of awareness of the client's discharge from the facility.

§46.39. Service Initiation.

(a) Negotiated move-in date. The facility must negotiate a move-in date with the Texas Department of Human Services (DHS) case manager and the client or the client's representative.

(b) Reserved space. The facility must reserve a living unit for three days from the agreed upon move-in date for each referred client. The facility may request another referral after three days if the move-in date is not re-negotiated.

(c) Client and facility agreement. The facility must have a written agreement with the client or the client's representative. Both parties must sign the written agreement before or at the time of admission. The written agreement must include the following:

(1) bedhold policies for hospital and nursing facility stays;

(2) personal leave policies and charges;

(3) eviction procedures;

(4) all available services in the facility; and

(5) charges for services not paid by DHS and charges not included in the facility's basic daily rate, as described in §46.15 of this chapter (relating to Additional Services and Fees).

(d) Health assessment and service plan.

(1) The facility must complete a health assessment and develop an individual service plan as described in §92.41(c) of this title (relating to Standards for Type A, Type B, and Type E Assisted Living Facilities).

(2) In addition to the items described in §92.41(c) of this title, the health assessment developed by the facility must contain the following items:

(A) vision patterns;

(B) skin conditions;

(C) body control problems; and

(D) vital signs, height, and weight.

(3) The health assessment and individual service plan must be completed:

(A) within 72 hours of admission to the facility; and

(B) by the appropriate person(s).

(i) The facility manager or a nurse must complete the health assessment and individual service plan.

(ii) A nurse must complete the medication administration portion of the health assessment for Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) clients. If the nurse is a licensed vocational nurse (LVN), a registered nurse (RN) must sign off on the medication administration portion of the health assessment.

§46.41. Required Services.

(a) Service delivery. The facility must provide services according to the service plan completed for the client.

(b) Required services. Services include:

(1) Personal care. The facility must provide or assist with personal care services identified on the service plan completed for the client. Personal care services are activities related to the care of the client's physical health that include at a minimum:

(A) bathing;

(B) dressing;

(C) grooming;

(D) routine hair and skin care;

(E) exercising;

(F) toileting;

(G) medication administration, including injections. This does not apply to the Community Care for Aged and Disabled (CCAD) Residential Care (RC) Program;

(H) transferring/ambulating. This does not apply to clients residing in a Type A assisted living facility;

(I) twenty-four-hour supervision. The facility must conduct and document in the client file checks or visits to each client to ensure that each client is safe and well. The checks or visits must be made as identified on the service plan completed for the client; and

(J) meal services. The facility must:

(i) provide meal services as described in §92.41(m) of this title (relating to Standards for Type A, Type B, and Type E Assisted Living Facilities);

(ii) offer dietary counseling and nutrition education to the client;

(iii) modify food texture, including:

(I) chopping, grinding, and mashing foods for clients who have trouble chewing; and

(II) cutting up food into bite size pieces for clients who have trouble cutting food; and

(iv) assist with eating, including:

(I) assistance with spoon-feeding in instances when the client is temporarily ill;

(II) bread buttering; and

(III) opening containers or pouring liquids for clients with hand deformities, paralysis, or hand tremors.

(2) Home management. The facility must provide or assist with activities related to housekeeping that are essential to the client's health and comfort, including:

(A) changing bed linens;

(B) housecleaning;

(C) laundering;

(D) shopping;

(E) storing purchased items in the client's living unit. This includes medical supplies delivered to Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) clients; and

(F) washing dishes.

(3) Transportation and escort.

(A) The facility must provide the client with transportation, escort, or both to:

(i) local community areas where a client may purchase items to meet his or her personal needs or conduct personal business according to the facility's published schedule;

(ii) recreational activities, field/community trips according to the facility's published schedule; and

(iii) the nearest available medical provider for medical appointments, therapies, and other medical care.

(B) The facility must make arrangements for other transportation for the client to the medical care provider of the client's choice if the client's medical provider is not the nearest available provider.

(4) Social and recreational activities. The facility must provide a minimum of four scheduled social and recreational activities per week.

(A) Activity requirements. The social and recreational activities must be:

(i) planned to meet the social needs and interests of the clients; and

(ii) listed on a monthly calendar that is posted in plain view at the facility at least one week in advance.

(B) Types of activities. Social and recreational activities include:

(i) activities that require group and client-initiated activities;
(ii) opportunities to interact with other people;
(iii) interaction, cultural enrichment, educational, or recreational activities; and
(iv) other social activities on site or in the community.

(5) Participation in the client assessment. The facility must designate someone who is familiar with the CBA AL/RC client's needs and service plan to participate with the client's assessment. The assessment will determine the Texas Index of Level of Effort (TILE) at both the annual assessment, and a requested re-TILE. Participation in the client assessment does not apply to the CCAD RC Program.

(6) Emergency care. The facility must provide emergency care as authorized by the case manager.

(A) Emergency care is assisted living services provided to clients while the case manager seeks a permanent living arrangement.

(B) Emergency care services do not apply to the CBA AL/RC program.

§46.43. Service Plan Changes.

(a) The facility must complete a new service plan anytime there is a need for a change in the client's service plan.

(b) The facility must implement service plan changes within seven days from the assessment date.

§46.45. Required Notifications.

(a) The facility must notify the Texas Department of Human Services (DHS) when one of the following happens:

(1) significant changes in the client's health and/or condition;
(2) the client temporarily enters an institution;
(3) serious occurrences or emergencies involving the client or facility staff;
(4) the client or the client's representative requests that services end;
(5) the client refuses to comply with the service plan;
(6) the client engages in discrimination in violation of applicable law;
(7) the client or the client's representative fails to pay copayment;
(8) the client uses ten personal leave days in the current calendar year;
(9) the client or the client's representative requests to move to another facility; or
(10) when the facility believes that a client's functional needs have changed such that it will impact the client's Texas Index of Level of Effort (TILE). This only applies to facilities providing assisted living services under the Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) Program that participate in the attendant compensation rate option.

(b) The facility must notify the client's DHS case manager orally or by facsimile about the change no later than one DHS workday after the change happens. If the facility's first notification is oral, the facility must send written notification to the case manager within five working days of the initial notification.

§46.47. Suspension of Services.

(a) The facility must suspend services when one of the following happens:

(1) the client dies;
(2) the client moves from the facility;
(3) the client is discharged because he threatens the health or safety of himself or other clients in the facility;
(4) the client is permanently admitted to an institution;

(5) the Texas Department of Human Services (DHS) enforces sanctions against the facility by terminating the contract;

(6) the client's eligibility is denied; or

(7) the case manager requests that services be suspended or terminated.

(b) The facility must notify the client's DHS case manager orally or by facsimile about the suspension no later than one DHS workday after services are suspended. If the facility's first notification is oral, the facility must send written notification to the case manager within five working days of the initial notification.

§46.49. Institutional Leave.

(a) Institution. An institution is defined as a hospital, nursing facility, state school, state hospital, or intermediate care facility serving persons with mental retardation or a related condition.

(b) Institutional leave. Institutional leave is when clients are absent from the facility because they temporarily enter an institution.

(c) Bedhold. The facility must hold the client's bed:

(1) for a Community Care for Aged and Disabled (CCAD) Residential Care (RC) client for:

(A) 60 days if the client is in a hospital; or

(B) 30 days if the client is in any other type of institution; and

(2) for a Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) client for 60 days if the client is in any type of institution.

(d) Bedhold charges. The facility must charge the client or the client's representative for bedhold during institutional leave.

(1) Bedhold charges for a CCAD RC client are the bedhold rate established by the Texas Department of Human Services (DHS), plus room and board charges.

(2) Bedhold charges for a CBA AL/RC client are the room and board charges.

(e) Refund of copayment. The facility must not charge the client or the client's representative more than the maximum amount allowed by DHS for bedhold. The facility must refund the client's copayment for the days the client uses institutional leave.

(1) The facility must refund any copayment paid by a CCAD RC client or the client's representative that is in excess of the bedhold amount. If the client's copayment amount is less than the bedhold charge, DHS pays the difference as described in §46.21 of this chapter (relating to Reimbursement).

(2) The facility must refund all copayments paid by a CBA AL/RC client or the client's representative.

(3) The refund must be made according to the procedures in §46.37(c) of this chapter (relating to Copayment and Room and Board).

(f) Billing during institutional leave. The facility must charge the client or the client's representative only the bedhold amount for the date of admission to an institution. The facility must charge the client or the client's representative the full rate for date of return.

(g) Notification of institutional leave. The facility must notify the DHS case manager of any institutional leave as described in §46.45 of this chapter (relating to Required Notifications).

§46.51. Personal Leave.

(a) Personal leave. A client is entitled to 14 days of personal leave per calendar year.

(b) Client charges. The facility must collect the entire copayment and room and board charges for all personal leave days.

(c) Texas Department of Human Services (DHS) payment during personal leave. The facility must not bill DHS for more than 14 days of personal leave taken by the client each calendar year.

(d) Notification of personal leave days. The facility must notify the DHS case manager of personal leave days as described under §46.45 of this chapter (relating to Required Notifications).

(e) Charge for exceeding personal leave days. The client is responsible for all charges for services if he exceeds the allowable limit of personal leave days.

§46.53. Client Terminations.

(a) Client discharge. The facility must convene an Interdisciplinary Team (IDT) meeting, as described in §46.35 of this chapter (relating to Interdisciplinary Team) before discharging a client, except when the client threatens the health or safety of others or himself. The facility must notify the DHS case manager as described under §46.47 of this chapter (relating to Suspension of Services).

(b) Assistance with move. The facility must help the client prepare for transfer or discharge.

(c) Refunds. The facility must refund the following:

(1) copayment and room and board, as described in §46.37(f) of this chapter (relating to Copayment and Room and Board); and

(2) trust fund balances, as described in §46.71 of this chapter (relating to Trust Fund Procedures for Client Discharge).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on _____.

Chapter 46, Contracting to Provide Assisted Living and Residential Care Services
Subchapter D, Trust Funds
TAC Section Number(s) §§46.61, 46.63, 46.65, 46.67, 46.69, 46.71

Final Action

200303649	TRD Docket Number For Proposed Action
6/27/03	Proposed Action Publication Date
X	New
X	Adopted With Changes

Effective Date:

X	9/1/03

The new sections are adopted under the Human Resources Code, Chapters 22 and 32, which authorizes DHS to administer public and medical assistance programs, and under Government Code, §531.021, which provides the Texas Health and Human Services Commission with the authority to administer federal medical assistance funds.

The new sections affect the Human Resources Code, §§22.0001-22.038 and §§32.001-

32.053.

§46.61. Trust Fund Management.

(a) Clients have the right to:

(1) perform their own money management;

(2) request that the facility provide or assist with money management; or

(3) designate another person to provide or assist with money management.

(b) The case manager will inform the facility if a client wishes the facility to provide or assist with money management.

(c) The facility must not require clients to request the facility provide or assist with money management. The facility must have the client's or the client's representative's written authorization to provide or assist with money management.

(d) The facility must provide a written statement of the trust fund rights and responsibilities regarding the client’s financial affairs. The written statement must:

(1) be provided to each client or client’s representative who chooses to have the facility provide or assist with money management;

(2) be provided at the time of admission or request; and

(3) include the following:

(A) a statement that the facility must not require clients to allow the facility to provide or assist with money management;

(B) the client or the client's representative's written request and authorization to provide or assist with money management; and

(C) any charge by the facility for providing or assisting with money management is included in the facility's basic rate.

§46.63. Trust Fund Bank Account.

(a) Bank account.

(1) The contracted assisted living facility must keep funds received from or on behalf of a client for a trust fund in a separate bank account from the facility's operating funds. The account must be identified as "Trustee, (Name of Facility), Client's Trust Fund Account."

(2) The facility may use the following type of checking accounts for the trust fund:

(A) a pooled checking account, which is a single checking account that contains all the personal funds received from each client utilizing the trust fund;

(B) a client-choice individual checking account, which is a single checking account that contains only the personal funds of a single client. The client or the client’s representative must request this type of trust fund in writing; or

(C) a facility-choice individual checking account, which is a single checking account that contains only the funds of a single client. This type of trust fund is set up for the convenience of the facility.

(b) Commingled funds. A facility may commingle the trust funds of private-pay clients and Texas Department of Human Services (DHS) clients.

(1) Each private-pay client or the client’s representative whose funds are commingled with DHS client funds must sign and date a permission form upon admission or at the time of request for trust fund services. The permission form must include:

(A) permission for the facility to commingle the personal funds of the private pay client with DHS clients;

(B) permission for the facility to maintain trust fund records of private-pay clients in the same manner as the DHS client's trust fund records; and

(C) a provision allowing inspection of the private-pay client's trust fund records by DHS staff.

(2) The facility must keep financial records of private pay clients with commingled funds in the same manner as the financial records of DHS clients as specified in this chapter.

(c) Banking charges.

(1) The facility is responsible for bank fees for the trust fund kept in a pooled checking account or in facility-choice individual checking accounts. The facility must not charge these fees to the client or the client's representative. The facility may report these fees as allowable costs on its cost report.

(2) The client or the client's representative is responsible for bank fees for the trust fund kept in client-choice individual checking accounts.

(3) The facility must not charge the client or the client's representative for the administrative handling of any allowable type of checking account. The facility may report these costs on its cost report.

(d) Interest earned. The facility must distribute the interest earned on the pooled checking account, if the pooled checking account is interest-bearing, to all clients utilizing the trust fund. The facility must prorate the actual interest earned to each client's account:

(1) at the time the financial institution pays the interest; and

(2) on the basis of the client's balance at the time the financial institution pays the interest.

§46.65. Trust Fund Transactions.

(a) Transactions.

(1) The facility must keep records of all trust fund transactions.

(2) Facility staff must record on the client's trust-fund ledger or deposit/withdrawal document at least the following:

(A) the date and amount of each deposit;

(B) the source of each deposit;

(C) the date and amount of each withdrawal;

(D) the reason for each withdrawal;

(E) the name of the person or entity who accepted the withdrawn funds; and

(F) the balance after each transaction.

(3) The client or the client's representative must sign for each withdrawal transaction at the time of the transaction.

(A) The signature must be on the trust-fund ledger, deposit/withdrawal document, or trust fund receipt.

(B) At least one witness must sign for each withdrawal transaction if the client or the client's representative cannot sign.

(C) A signature is not required if the payment meets the definition of a recurring payment as described in subsection (c) of this section.

(4) The facility must record transactions within 14 days of occurrence.

(b) Bulk purchases. The facility may make bulk purchases for items used by multiple clients.

(1) The bulk purchase must be traceable to individual clients.

(2) The receipt for the bulk purchase must show the following:

(A) the names of the clients for whom the purchase was made; and

(B) the portion of the total price charged to each client.

(3) The facility must not charge the client or the client's representative more than the actual cost of the client's portion of items that are purchased in bulk.

(c) Recurring payments.

(1) The facility must obtain the client's or the client's representative's written request and authorization to make recurring payments on behalf of the client. The written authorization must include the:

(A) name of the business or entity to which the recurring payment is made;

(B) amount of the recurring payment. If the recurring payment is not a set amount, the authorization must include the method for determining the amount of the recurring payment;

(C) date the payment will begin; and

(D) signature and signature date of the client or the client's representative.

(2) The client or the client's representative must request and authorize the facility to stop recurring payments on behalf of the client.

(A) The authorization may be oral or written.

(B) The facility must document the request, including the:

(i) name of the business or entity to which the recurring payment is made; and

(ii) date the payment will stop.

(3) The facility is not required to have a receipt for recurring payments made on behalf of the client.

(d) Petty cash fund.

(1) A petty cash fund is part of the pooled checking account trust fund kept on hand in cash by the facility. The petty cash fund is used for disbursement to clients for the purchase of minor items.

(2) The facility must keep the petty cash fund locked.

(3) The facility must set a dollar limit for petty cash transactions.

(A) The facility must document:

(i) the dollar limit of petty cash transactions; and

(ii) a list of any exceptions to the petty cash transaction limit, if applicable.

(B) The facility must follow the procedures in subsection (a) of this section for withdrawals that exceed the petty cash transaction limit.

(4) The facility must keep records of all petty cash fund transactions. The petty cash fund record must be a:

(A) petty cash fund ledger; or

(B) petty cash fund receipt.

(5) A petty cash fund ledger or receipt must include the:

(A) name of the client;

(B) date of the withdrawal;

(C) amount of the withdrawal; and

(D) signature of client or the client's representative, or at least one witness if the client or the client's representative cannot sign.

(6) The facility must use the following guidelines to replenish the petty cash fund:

(A) Count the money in the petty cash fund.

(B) Determine the difference between amount in the petty cash fund and the amount needed in the petty cash fund.

(C) Cash a check for the difference between the amount in the petty cash fund and the amount needed in the petty cash fund.

(i) Write the check for cash on the appropriate checking account, either the:

(I) pooled trust fund checking account; or

(II) individual client trust fund checking account.

(ii) Indicate "petty cash fund" in the "memo" line of the check.

(D) Put the cash in the petty cash fund.

(7) The facility must reconcile the petty cash fund at least monthly.

(8) The facility must follow the requirements for transactions in subsection (a) of this section to post petty cash fund transactions to the trust fund ledger. However, the client's or the client's representative's signature is not required on the trust fund ledger or trust fund receipt if the client's or the client's representative's signature is on the petty cash fund ledger or receipt.

(e) Receipts.

(1) A trust fund receipt is required when a direct payment is made from the client's trust fund. The facility may use printed receipts from vendors as trust fund receipts only if:

(A) all elements from paragraph (4) of this subsection are present; or

(B) any missing elements from paragraph (4) of this subsection are added.

(2) A trust fund receipt is required when a payment is received by the facility on behalf of a client. This is not applicable to funds direct-deposited to the trust fund account.

(3) A trust fund receipt is not required when the client or the client's representative makes a direct purchase with funds withdrawn from the trust fund. The withdrawn funds must meet the requirements listed in subsection (a) of this section.

(4) A trust fund receipt must contain the:

(A) name of the client;

(B) month, day, and year the receipt was written or created;

(C) total amount of money spent or received for the client;

(D) specific item(s) purchased; and

(E) name of the business or entity from which the purchase was made or the payment received.

(5) A trust fund receipt may contain the signature of the client or the client's representative for payments made from the trust fund. At least one witness must sign for each payment made if the client or the client's representative cannot sign.

(f) Limitations on withdrawals. The facility must not use the client's personal funds to purchase any item or service that the Texas Department of Human Services requires the facility to provide. The facility must purchase additional items or service with the client's personal funds only as described in §46.15 of this chapter (relating to Additional Services and Fees).

§46.67. Trust Fund Documentation.

(a) Accounting and records.

(1) The facility must keep written records of all financial transactions involving the client's personal funds that the facility is holding, safeguarding, and accounting. The written records may be in any format.

(2) The facility must keep the accounting records in accordance with generally accepted accounting principles (GAAP).

(3) The facility must keep records in accordance with its fiduciary duties for client trust funds.

(4) The facility must include at least the following in the accounting records:

(A) each client's name;

(B) identification of each client's representative or person assigned to receive the client's income, if any;

(C) admission date;

(D) each client's earned interest, if any;

(E) documentation of each transaction; and

(F) receipts for purchases and payments, including cash register tapes or sales statements from a seller.

(b) Quarterly statement. The facility must provide quarterly statements to the client or the client's representative, as described in §92.125(a)(3)(L) of this title (relating to Resident's Bill of Rights and Provider Bill of Rights).

(c) Access to trust fund records.

(1) The facility must make an individual client's financial record and supporting documents available at any time during working hours to the client, the client's representative, and the Texas Department of Human Services.

(2) This review can be made without prior notification.

§46.69. Trust Fund Refunds.

(a) The facility must return the full balance of the client's personal funds held in the facility to the client or the client's representative immediately upon request if the request is made during normal business hours. For purposes of this subsection, normal business hours are 8:00 a.m. to 5:00 p.m. on working days, or at the beginning of the next normal business hours if the request is received during hours other than normal business hours.

(b) The facility must return the full balance of the client's personal funds that the facility has deposited in any bank account to the client or the client's representative within ten working days of request. This refund must include any interest reported as of the date of the request.

§46.71. Trust Fund Procedures for Client Discharge.

(a) Client transfer.

(1) The facility must write a check to the resident for all funds held in the pooled checking account. This must include any interest accrued.

(2) The facility must complete the transfer within ten working days of the effective date of the transfer.

(3) The facility must not make any payments out of a client's trust fund after the effective date of transfer, except as described in this subsection.

(4) The cleared check will suffice as a receipt.

(b) Client discharge.

(1) The facility must refund the discharged client's personal funds and provide a final accounting of those funds to the client or the client's representative either:

(A) in person; or

(B) by mail via certified return receipt.

(2) The facility must complete the refund and provide a final accounting within ten working days of the date of discharge, or the date of the facility's awareness of the client's discharge, whichever is later.

(3) The facility must not make any payment out of a discharged client's trust fund, except as described in this subsection.

(4) The facility must maintain the following documentation in the client's trust fund record:

(A) a copy of the final accounting of the client's personal funds;

(B) the amount refunded to the discharged client or the client's representative;

(C) the date the refund was made. The date the refund was made is either:

(i) the date the funds were refunded in person; or

(ii) the date the certified return receipt shows the refund was mailed; and

(D) the method of refund. The facility must:

(i) obtain the signature of the client or the client's representative if the refund was in cash; or

(ii) document the check number if the refund was made by check.

(c) Client death.

(1) The facility must refund the deceased client's personal funds and provide a final accounting of those funds to the beneficiary, heir, or executor of the deceased client's estate either:

(A) in person; or

(B) by mail via certified return receipt.

(2) The facility must complete the refund and provide a final accounting within 30 days of awareness of the client's death, if the beneficiary, heir, or executor is known, located, or identified. The facility must make a bona fide effort to locate the beneficiary, heir, or executor of a

deceased client’s estate within 30 days.

(3) The facility must not make any payments out of a deceased client's trust fund, except as described in this subsection.

(4) The facility must maintain the following documentation in the client trust fund record:

(A) a copy of the final accounting of the client's personal funds;

(B) the amount refunded to the beneficiary, heir, or executor of the deceased client's estate;

(C) the date the refund was made. The date the refund was made is either:

(i) the date the funds were refunded in person; or

(ii) the date the certified return receipt shows the refund was mailed; and

(D) the method of refund. The facility must:

(i) obtain the signature of the client or the client’s representative if the refund was in cash; or

(ii) document the check number if the refund was made by check.

(5) The facility must use the following procedures to clear the client's account if it is unable to locate or identify the beneficiary, heir, or executor of a deceased client's estate within 30 days:

(A) The facility must send the personal funds of the deceased client to the Texas Department of Human Services (DHS), Fiscal Division, P.O. Box 149055, Austin, Texas 78714-9055 with the following information:

(i) the client's name;

(ii) the client's social security number; and

(iii) the amount of money being submitted to DHS for escheat.

(B) The facility must maintain the following in the client trust fund record:

(i) documentation of the facility's efforts to locate the beneficiary, heir, or executor of a deceased client's estate; and

(ii) proof of submission of the personal funds of a deceased client to DHS.

(d) Contract assignment.

(1) The assignor (the facility transferring the contract) must transfer the bank balances of the trust fund to the assignee (the facility to which the contract assignment is made) either:

(A) in person; or

(B) by mail via certified return receipt.

(2) The assignor must complete the transfer within five working days of the effective date of the contract assignment.

(3) The assignor must not make any payments out of a client's trust fund after the effective date of the contract assignment, except as described in this subsection.

(4) The assignor must provide the assignee with a list of the clients who are utilizing the trust fund and their balances.

(5) The assignee must provide the assignor with a receipt for the transfer of these funds. The receipt must contain the following elements:

(A) the date of the transfer of funds. The date the transfer was made is either the:

(i) date the funds were refunded in person; or

(ii) date the certified return receipt shows the refund was mailed;

(B) the name of the assignor;

(C) the amount received by the assignee; and

(D) the check number for the transfer of funds.

(6) The assignor must keep the receipt for audit purposes.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on _____.